PIVOT
OCCUPATIONAL HEALTH

Authorization for Examination or Treatment

(Patient Must Present Photo ID at Time of Service)

Employer:_____ **Today's Date**:_____

Location:_____ **Authorized By**: _____

Employer Phone No.:_____ **Employer Fax No**: _____

Employee:_____ **Employee Date of Birth**:_____

Please check all that apply:

☐ **Work Injury/Illness**

Date of Injury _____ Claim# (if available) _____ Body Part _____

Physical Examination

☐ Pre-placement ☐ DOT ☐ Periodic/Annual ☐ Exit ☐ Return to Work ☐ Fitness for Duty

☐ Respirator Clearance ☐ Asbestos ☐ Hazmat ☐ Medical Surveillance ☐ Other:_____

Substance Abuse Testing

☐ Federally regulated drug screen ☐ Non-regulated drug screen ☐ Collection only

Testing Authority: ___FMCSA ___FAA ____FRA ___FTA ___PHMSA ___USCG

☐ Breath Alcohol ☐ Hair Test ☐ 10 panel ☐ 5 panel ☐ Rapid 10 panel

☐ Rapid 5 panel ☐ Other: _____

Reason for Substance Abuse Testing

☐ Pre-placement ☐ Reasonable Cause ☐ Post-accident ☐ Random ☐Return to Duty ☐ Follow-up

Other Services

☐ Respirator Fit Test ☐ Audiogram ☐ PPD ☐ Pulmonary Function Test ☐ EKG ☐ Chest x-ray

☐ Vaccination:_____ ☐ Other:_____

Special instructions/comments:_____

_____

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For individual office hours and locations visit **www.PivotOccHealth.com**